Initial Accreditation or Self-Study Application Payment Sheet

**For Calendar Year 2024 Only**

**NOTE: This completed payment sheet MUST be submitted with all forms of payment**

Please Note: Only to be used for an initial accreditation or self-study application sent between **January 1, 2024 and December 31, 2024.**  If not, please contact the Commission Staff for the correct Payment Sheet.

**2024 Initial Accreditation or Self-Study** **Application Fee and Amount Due:**

Advanced and Allied Programs = $16,850; Predoctoral Dental Programs = $67,400

International Predoctoral Dental Programs = $76,660 (Contact CODA for International Payment Sheet)

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| **Please Remit Payment To:****American Dental Association****Attn: Accounts Receivable for** **Commission on Dental Accreditation** **28094 Network Place****Chicago, IL 60673-1280** | **All forms of payment must include the following:*** **“Remit Payment To” address (exactly as noted to the left)**
* **This payment sheet with all information completed, including institution and discipline.**
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| To pay by credit card, please fill out this form and mail to the “Remit Payment To” address below, or Fax it to 312-440-2567.Circle One: Visa Mastercard American Express Contact Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Card Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Name on Card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature of Card Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| Once payment and your Initial Accreditation or Self-Study Application is received, you will receive confirmation from CODA.Name of Institution: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Contact Name and Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| Initial Accreditation or Self-Study Application for : (Please Circle One): DPH ENDO OMP OMROMS OMS-Fellowship ORTHO ORTHO-Fellowship PEDIATRIC DENTISTRYPERIO PROS GPR-12 GPR-24 AEGD-12 AEGD-24 DENTAL ANESTHESIOLOGY ORAL MEDICINE OROFACIAL PAIN DENTAL ASSISTING DENTAL HYGIENE DENTAL LAB TECH DENTAL THERAPY PREDOCTORAL PREDOCTORAL INTERNATIONAL |

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| FOR OFFICE USE ONLY: Please Credit 160-0050-005-43020 |